STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name and Address of Insured (Use street address only) SEGELMAN SHAW LLC 16 SQUADRON BOULEVARD SUITE 106 NEW CITY , NY 10956 Work Location Of Insured (Only required If coverage Is specifically limited To certain locations In New York State, i.e., a Wrap-Up Policy)	1b. Business Telephone Number Of Insured 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 52-2422767
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) County of Rockland Office of Consumer Protection 18 New Hempstead Rd 6th Floor New City, NY 10956	3a. Name of Insurance Carrier WESCO INSURANCE COMPANY 3b. Policy Number of entity listed in box "1a.": 0229273 3c. Policy effective period: 5/19/2016 to 12/31/2017

4. Policy covers:
a. ☒ All of the employer's employees eligible under the New York Disability Benefits Law
b. ☐ Only the following class or classes of the employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability Benefits insurance coverage as described above.

Date Signed 5/19/2016 By _____

(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 800-535-2711 Title Vice President

IMPORTANT: If box "4a" is checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.
If box "4b" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 328 State Street, Schenectady, NY 12305.

PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" of Part 1 has been checked)

State of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____

(Signature of NYS Workers' Compensation Board Employee)

Telephone Number _____ Title _____

Please Note: Only insurance carriers licensed to write NYS disability benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. **Insurance brokers are NOT authorized to issue this form.**

DB-120.1 (9-15)

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in box "3" on this form is certifying that it is insuring the business referenced in box "1a" for disability benefits under the New York State Disability Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in box "2".

Will the carrier notify the certificate holder within 10 days of a policy being cancelled for non-payment of premium or within 30 days if cancelled for any other reason or if the insured is otherwise eliminated from the coverage indicated on this certificate prior to the end of the policy effective period? ☐ YES ☒ NO

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This certificate may be used as evidence of a Disability Benefits contract of insurance only while the underlying policy is in effect.

Please Note: Upon the cancellation of the disability benefits policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of NYS Disability Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

DISABILITY BENEFITS LAW

§220. Subd. 8

(a) The head Of a state Or municipal department, board, commission Or office authorized Or required by law To issue any permit For Or In connection With any work involving the employment Of employees In employment As defined In this article, And Not withstanding any general Or special statute requiring Or authorizing the issue Of such permits, shall Not issue such permit unless proof duly subscribed by an insurance carrier Is produced In a form satisfactory To the chair, that the payment Of disability benefits For all employees has been secured As provided by this article. Nothing herein, however, shall be construed As creating any liability On the part Of such state Or municipal department, board, commission Or office To pay any disability benefits To any such employee If so employed.

(b) The head Of a state Or municipal department, board, commission Or office authorized Or required by law To enter into any contract For Or In connection With any work involving the employment Of employees In employment As defined In this article, And notwithstanding any general Or special statute requiring Or authorizing any such contract, shall Not enter into any such contract unless proof duly subscribed by an insurance carrier Is produced In a form satisfactory To the chair, that the payment Of disability benefits For all employees has been secured As provided by this article.